Headache Symptom Record Guidelines

Date: ______________________

Patient Name: ______________________

Patient ID: ______________________

Instructions:

Please record your headache symptoms accurately using the following guidelines:

1. Headache Details

- **Date and Time: ______________________**
- **Duration: ______________________**
- **Type of Headache:** (e.g., Migraine, Tension, Cluster) ______________________

2. Pain Rating

On a scale of 1 to 10, where 1 is no pain and 10 is the worst pain imaginable, please rate your headache:

Pain Level: ___________

3. Associated Symptoms

Please check all symptoms that apply:

- Nausea
- Sensitivity to Light
- Sensitivity to Sound
- Visual Disturbances
- Other: ______________________

4. Triggers

Please list any known triggers that may have contributed to your headache:

Triggers: ______________________

5. Treatment

Please document any treatment administered:

Treatment/Medication: ______________________

Time Taken: ______________________

6. Additional Notes

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Thank you for your accurate record keeping!